

|   |  |   |  |  |  |   |                            |
|---|--|---|--|--|--|---|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155527 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                |  | (X3) DATE SURVEY<br>COMPLETED<br>04/28/2011 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>PINEKNOLL REHABILITATION CENTRE |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>160 NORTH MIDDLE SCHOOL ROAD<br>WINCHESTER, IN47394 |  |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |   |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE |
| F0000   | <p>This visit was for the Investigation of Complaint IN00089217.</p> <p>Complaint IN00089217 substantiated, federal/state deficiency related to the allegations are cited at F223.</p> <p>Survey dates: April 28, 2011</p> <p>Facility number: 000532<br/>Provider number: 155527<br/>AIM number: 100267180</p> <p>Survey team:<br/>Betty Retherford RN TC<br/>Delinda Easterly RN</p> <p>Census bed type:<br/>SNF: 9<br/>SNF/NF: 46<br/>Total: 55</p> <p>Census payor type:<br/>Medicare: 10<br/>Medicaid: 31<br/>Other: 14</p> |   |  | F0000  |  |   |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

|   |   |   |  |  |  |   |                            |
|---|---|---|--|--|--|---|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155527 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                |  | (X3) DATE SURVEY<br>COMPLETED<br>04/28/2011 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>PINEKNOLL REHABILITATION CENTRE |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>160 NORTH MIDDLE SCHOOL ROAD<br>WINCHESTER, IN47394 |  |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |   |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |   | (X5)<br>COMPLETION<br>DATE |
| F0223<br>SS=A   | <p>Total: 55</p> <p>Sample: 5</p> <p>PineKnoll Rehabilitation Centre was found to be in substantial compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00089217.</p> <p>Quality review completed 4-29-11<br/>Cathy Emswiller RN</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from physical and verbal abuse for 1 of 5 residents reviewed for staff to resident treatment in a sample of 5. (Resident #B)</p> |   |  | F0223  | <p>1. Resident #B was not harmed and CNA #1 was terminated.2. All other residents have the potential to be affected. Upon review, if abuse was noted, the employee responsible was immediately suspended and an investigation started.3. The facility's abuse policy was reviewed and no changes are indicated at this time. Facility staff have been re-educated on the</p> |   | 05/03/2011                 |

|   |   |   |  |  |  |   |                            |
|---|---|---|--|--|--|---|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155527 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                |  | (X3) DATE SURVEY<br>COMPLETED<br>04/28/2011 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>PINEKNOLL REHABILITATION CENTRE |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>160 NORTH MIDDLE SCHOOL ROAD<br>WINCHESTER, IN47394 |  |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |   |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |   | (X5)<br>COMPLETION<br>DATE |
|   | <p>Findings include:</p> <p>1.) The clinical record for Resident #B was reviewed on 4/28/11 at 10:00 a.m.</p> <p>Diagnoses for Resident #B included, but were not limited to, Depression with agitated features, anxiety, and Alzheimer's disease.</p> <p>An admission Minimum Data Set Assessment, dated 2/18/11, indicated Resident #B was severely cognitively impaired and required the supervision of the staff for toileting.</p> <p>Review of a "Facility Incident Reporting Form", dated 4/7/11, included, but was not limited to, the following:</p> <p>"Brief Description of Incident: [Name of CNA #1] was ambulating arm and arm with the resident. When they reached [name of CNA #2] [CNA #1] was noted to jerk the resident's arm toward [CNA #2].</p> |   |  |  | <p>abuse policy (See Attachment A). An Abuse Prohibition Review form has been implemented (See Attachment B)4. The Social Services director or Designee will interview 3 residents or 3 resident family members and 3 staff members and complete the Abuse Prohibition form on scheduled work days as follows: Daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.5. The above corrective actions will be completed on or before May 3, 2011</p> |   |                            |

|   |   |   |  |  |  |   |                            |
|---|---|---|--|--|--|---|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155527 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                |  | (X3) DATE SURVEY<br>COMPLETED<br>04/28/2011 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>PINEKNOLL REHABILITATION CENTRE |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>160 NORTH MIDDLE SCHOOL ROAD<br>WINCHESTER, IN47394 |  |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |   |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE |
|   | <p>[CNA #1] indicated the resident was squatting on the other end [the other end of the unit] and then [CNA #1] commented 'Take her to the Bathroom!' [Name of LPN #3] witnessed [CNA #1] actions and indicated she was abrupt and rough with the resident but doesn't think [CNA #1] was trying to hurt the resident. [LPN #3] also indicated [CNA #1] seemed very disgusted with the resident by the tone of her voice she was using. [CNA #2] indicated she had to tell [CNA #1] to calm down and not to handle the resident in that manner. [CNA #2] indicated [CNA #1] seemed frustrated but does not think [CNA #1] was being purposeful in her actions. The resident's physician and family were updated on the occurrence."</p> <p>The form indicated a head to toe assessment of the resident was completed and no injuries were noted. The form indicated CNA #1 was suspended pending investigation and subsequently</p> |   |  |  |  |   |                            |

|   |  |   |  |  |  |   |                            |
|---|--|---|--|--|--|---|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155527 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                |  | (X3) DATE SURVEY<br>COMPLETED<br>04/28/2011 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>PINEKNOLL REHABILITATION CENTRE |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>160 NORTH MIDDLE SCHOOL ROAD<br>WINCHESTER, IN47394 |  |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |   |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE |
|   | <p>terminated. The form indicated an abuse inservice was completed for all the staff.</p> <p>An "Employee Warning" form, dated 4/7/11 and signed by CNA #1 on 4/11/11, indicated CNA #1 had been terminated due to a violation of the code of conduct "mistreatment of a resident."</p> <p>An inservice attendance form, dated 1/8/11, indicated CNA #1 had attended an abuse inservice on that date.</p> <p>Review of the facility investigation forms, provided by the Director of Nursing on 4/28/11 at 10:00 a.m., indicated an investigation had been completed and additional staff and residents had been interviewed following the 4/7/11 incident for other possible concerns of abuse and none were found. The forms indicated another abuse inservice was completed following the 4/7/11 incident and the incident had been reported to the Indiana State</p> |   |  |  |  |   |                            |

|   |   |   |  |  |  |   |                            |
|---|---|---|--|--|--|---|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155527 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                |  | (X3) DATE SURVEY<br>COMPLETED<br>04/28/2011 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>PINEKNOLL REHABILITATION CENTRE |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>160 NORTH MIDDLE SCHOOL ROAD<br>WINCHESTER, IN47394 |  |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |   |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE |
|   | <p>Department of Health.</p> <p>During an interview on 4/28/11 at 11:30 a.m., the Director of Nursing indicated she did not feel CNA #1 had intended to hurt Resident #B but her actions were inappropriate and unacceptable. The Director of Nursing indicated CNA #1 had been terminated by the facility for resident mistreatment and had not worked with any other residents after the 4/7/11 incident noted above.</p> <p>2.) Review of the current facility policy, dated 1/06, provided by the Director of Nursing on 4/28/11 at 10:00 am, titled, "Abuse Prohibition, Reporting and Investigation Policy and Procedure", included, but was not limited to, the following:</p> <p>"It is the policy of Hoosier Enterprises that reports of abuse will be communicated to, and thoroughly investigated by, the correct authority.</p> |   |  |  |  |   |                            |

|   |  |   |  |  |  |   |                            |
|---|--|---|--|--|--|---|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155527 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                |  | (X3) DATE SURVEY<br>COMPLETED<br>04/28/2011 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>PINEKNOLL REHABILITATION CENTRE |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>160 NORTH MIDDLE SCHOOL ROAD<br>WINCHESTER, IN47394 |  |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |   |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE |
|   | 1. Hoosier Enterprises will not<br>permit residents to be subjected to<br>abuse by anyone, including<br>employees, ...."<br><br>This federal tag relates to complaint<br>number IN00089217.<br><br>3.1-27(a)(1)<br>3.1-27(b) |   |  |  |  |   |                            |